TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
UNIVERSAL DME LLC

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-16-3614-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
AUGUST 5, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 06/06/2016 we submitted our claim for payment to Texas Mutual in the amount of $8000.00. On 07/07/2016 the claim was denied. Per EOB it stated that services denied at the time authorization/pre-certification was requested. We have the supporting documentation attached along with their company's authorization #12240300. On 07/19/2016 we sent our appeal for payment, we explained to them that we had authorization approved which was certified by their company. On 07/26/2016 our appeal was denied again stating same reason for all codes."

Amount in Dispute: $8,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "*Texas Mutual did not preauthorize the bone growth stimulator*."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 27, 2016	HCPCS Codes E0748 Bone Growth Stimulator	$8,000.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-198-Precertification/authorization exceeded.
   - CAC-39-Services denied at the time authorization/pre-certification was requested.

- 275-The health care provider requested preauthorization, however, the insurance carrier denied approval (according to chapter 134).
- 759-Service not included in and/or exceeds preauthorization approval.
- CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 891-The insurance company is reducing or denying payment after reconsideration.

Issues

Does a preauthorization issue exist?

Findings

HCPCS code E0748 is defined as "Osteogenesis stimulator, electrical, noninvasive, spinal applications."

According to the explanation of benefits, the respondent denied reimbursement for HCPCS code E0748 based upon a lack of preauthorization.

28 Texas Administrative Code §134.600(p)(9), states,

> Non-emergency health care requiring preauthorization includes: (9) all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental).

The requestor contends that "Per EOB it stated that services denied at the time authorization/pre-certification was requested. We have the supporting documentation attached along with their company's authorization #12240300. On 07/19/2016 we sent our appeal for payment, we explained to them that we had authorization approved which was certified by their company."

A review May 9, 2016 preauthorization report states "Per Physician Advisor, and per mutual agreement with Stormie, authorization is given for Continuous Cryo unit for Rental for 7 days E0217 and TENS Unit for Rental for 1 month E0730 with Conductive Garment for Purchase E0731…NU Bone Growth Stimulator E0748X1 non-certified."

The Division finds that a preauthorization issue does exist in this dispute. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	09/21/2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.